300 Inpatient Psychiatric

301 Psychiatric Payment Rates for Urban Hospitals -- The Medicaid program covers both acute care and free-standing psychiatric hospitals for acute patients. Chronic patients with long-term needs will be served primarily through the Utah State Hospital, the community mental health centers, and other mental health providers. The payment rates for acute care and free-standing psychiatric hospitals are based on the lengths of stay published by the Commission on Professional and Hospital Activities, Professional Activities Study (PAS) 50th percentile. In recognition of the difference in treating children and adults, there is a different payment system for patients under 20 years old and those over 20 years old. The age used to determine payment will be at the day of discharge.

310 Adult Patients -- The rates for patients 20 years old and older are based on the average ALOS published in the PAS for DRGs 425 through 432. A statewide DRG rate will be paid for each qualifying discharge. Psychiatric services for patients, ages 21-65, in facilities that are IMDS are not reimbursed. Pricing will be based on the FY 1987 paid claims history. Outlier thresholds are set using the ALOS at the PAS 50th percentile plus six days. Approved days above the threshold are paid a per diem rate. The per diem is calculated from the base DRG payment divided by the ALOS. Outlier days are subject to prepayment review. Patients discharged from psychiatric units and admitted for inpatient surgery will be counted as one hospitalization. Only one DRG will be paid.

320 Patients Under Age 20 -- Payment will be based on a fixed fee per discharge. The fee schedule will be based on the age of the patient and the average length of stay specified in "Pediatric Length of Stay (ALOS) by Diagnosis and Operations, United States," published by the Commission on Professional and Hospital Activities. Outlier thresholds are set using the ALOS at the PAS 50th percentile plus six days. Approved days above the threshold are paid a per diem rate. The per diem is calculated from the base DRG payment divided by the ALOS. Patients discharged from psychiatric units and admitted for inpatient surgery will be counted as one hospitalization.

330 Psychiatric Payment Rates for Rural Hospitals -- Rural hospitals are defined by the Standard Metropolitan Statistical Area (SMSA). Rural hospitals located in Utah are paid a percentage of allowable usual and customary charges. This payment percentage is the same as the percentage for all other general acute hospital services.

1/14/94

400 Adjustment for Disproportionate Share Hospitals

410 INTRODUCTION -- This section establishes criteria for identifying and paying disproportionate share hospitals (DSH). For the purpose of paying disproportionate share hospitals, there are four types of hospitals: First, private hospitals licensed as general acute hospitals located in urban counties; Second, general acute hospitals located in rural counties; Third, the State Psychiatric Hospital; Fourth, the State Teaching Hospital.

411 OBSTETRICAL SERVICES REQUIREMENT -- Hospitals offering non-emergency obstetrical services must have at least two obstetricians providing such services. For rural hospitals, an "obstetrician" is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital. This requirement does not apply to children's hospitals nor to hospitals which did not offer non-emergency obstetrical services as of December 22, 1987.

412 MINIMUM UTILIZATION RATE -- All DSH hospitals must maintain a minimum of 1% Medicaid Utilization Rate.

413 HOSPITALS DEEMED DISPROPORTIONATE SHARE -- A hospital is deemed a disproportionate share provider if, in addition to meeting the obstetrical (Section 411) and the Medicaid utilization rate requirements, it meets at least one of the following four conditions:

(A) The hospital's combined utilization rate for Utah Medicaid Assistance Program (UMAP) and Medicaid inpatient is at least one standard deviation above the mean utilization rate (Medicaid and UMAP). The disproportionate share computed percentage is based on the number of percentage points that an individual hospital indigent patient days (Medicaid and UMAP) exceed the statewide average plus one standard deviation.

(B) The hospital's low-income utilization exceeds 25% as defined in Section 1923(b)(3) of the Social Security Act.

(C) The hospital has more than 14% Medicaid and UMAP utilization under the Utah Medicaid fee-for-service plan.

(D) Hospitals located in rural counties qualify because they are sole community hospitals. A sole community hospital is defined as a hospital that is located more than 29 miles from another hospital.

414 PAYMENT ADJUSTMENT FOR GENERAL ACUTE URBAN (excluding State Teaching Hospital) -- General Acute Urban Hospitals (Paid by DRGs) with a DSH Factor of 2% or more are paid a DSH amount on each inpatient claim. The DSH Factor is derived by dividing the combined Medicaid and UMAP inpatient days by the total general acute days for each hospital and multiplying by a ceiling factor of .13. The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The resulting figure is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor. The minimum disproportionate share payment is 2% of the calculated DRG payment. The maximum is 7% of the calculated DRG payment. Hospitals with a calculated DSH factor of less than 2% do not qualify for a DSH payment.

415 PAYMENT ADJUSTMENT FOR GENERAL ACUTE RURAL -- General Acute Rural Hospitals (which are paid at 93% of billed charges) are paid a DSH payment amount on each inpatient claim. The DSH factor is derived by dividing the combined Medicaid and UMAP inpatient days by the total general acute days for each hospital and multiplying by a ceiling factor of .13. The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The resulting percentage (DSH factor) is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid payment times the DSH factor. The minimum disproportionate share payment is 1% of the calculated ~~DRG~~ MEDICAID payment. The maximum is 7% of the calculated ~~DRG~~ MEDICAID payment.

416 PAYMENT ADJUSTMENT FOR STATE PSYCHIATRIC HOSPITAL -- The State Psychiatric Hospital is reimbursed on a retrospective annual cost settlement basis. Its DSH payment is calculated on the proportion of Medicaid and UMAP days to total patient census. The Medicaid and UMAP proportion is multiplied by a ceiling factor of 0.5. The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The result is the DSH factor which in turn is applied to the cost settlement amount. This is subject to a minimum of 1% and a maximum of 9% OF THE MEDICAID PAYMENT.

416A CAPITALIZATION OF ASSETS -- In establishing allowable cost, the Utah State Hospital is required to capitalize only those assets costing more than $5,000.

417 PAYMENT ADJUSTMENT FOR STATE TEACHING HOSPITAL -- The hospital's DSH factor is the ratio of Utah Medicaid, UMAP, out-of-state Medicaid, and charity patient days to total days times a ceiling factor of 0.5. The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The resulting DSH factor is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor. The minimum disproportionate share payment is 1% of the Medicaid payment. The maximum is 9% of the Medicaid payment.

420 EXCEPTIONALLY HIGH COST -- Disproportionate share hospitals receive an additional payment for service involving exceptionally high costs for children under the age of six. Exceptionally high cost is defined as inpatient hospital charges in excess of $500,000. The additional payment will be one tenth of 1% of the Medicaid payment calculated without the outlier payment. To avoid duplicate payment, this section does not apply to those hospital stays where payment has been increased under section 260 of this plan.

421 METHOD AND TIMING OF DSH PAYMENTS -- Each claim for payment to qualified providers includes a percentage add-on at the level specified for that facility. Each quarter the total amount of DSH to all qualified facilities is calculated. The amount, along with any preceding quarters for the current fiscal year, is used to predict the total amount that will be paid. If this exceeds the current DSH allotment, the payment level will be adjusted downward for any facilities predicted to be overpaid.

ATTACHMENT 4.19-A

500 Inpatient Rehabilitation Services

501 General -- Because of the wide variation in the length of stay for rehabilitation services under DRG 462, there is a need to refine the DRG criteria. Rehabilitative services under DRG 462 are subdivided into five groups. Each group has an established average length of stay and a base payment calculated in accordance with Section 122 of Attachment 4.19-A. Payments are made for outlie above the designated threshold consistent wit other DRG payments.

510 Designated Groups -- Rehabilitation is subdivided into the following groups: 1) Spinal -- Para 2,) Spinal -- Quad, 3) Head, 4) Stroke and 5) Other. "Spinal -- Para" includes patients with paraplegia who require an initial intensive inpatient rehabilitation program. "Spinal -- Quad" includes patients with quadriplegia who require an initial intensive inpatient rehabilitation program. "Head" includes patients with head trauma and with documented neurological deficits who require an initial intensive inpatient rehabilitation program. "Stroke" includes patients needing an initial intensive inpatient program because of disability due to a neurological deficit secondary to a recent cerebrovascular disease. "Other condition" includes patients with a neurological/neuromuscular disease or other disorder requiring intensive inpatient rehabilitation. The State Medicaid Agency requires prior approval of all classifications.

520 Payment Rates -- Payment rates are calculated based on the 1989 average charge for each of the five DRG groups identified in Section 510. Paid claims history from FY 1989 is used to identify the average charge per discharge and the average length of stay for each of five groups of rehabilitation patients. The average charge for each group of patients is factored to make the rehabilitation DRG payment rates consistent with the aggregate of all other DRG payment rates. The outlier thresholds are calculated by multiplying the average length of stay by 130%. The 130% was negotiated with representatives of those hospitals with rehabilitation units.

530 Upper Payment Limit -- Because of the unusually long lengths of stay and because, on occasion, there are very short stays, an upper payment limit is established. The upper payment limit is set at 80% of charges for the period July 1, 1990 through June 30, 1991 and 100% of charges for the period after June 30, 1991. In assessing the Medicare upper payment limit, the payments for rehabilitation services are combined with other DRG payments so that the comparison is made for the aggregat of all DRGs and all hospitals.
4/22/93

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